STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGOLAND CHRISTIAN VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 14, 15,16, 17, 18, 21, and 23, 2011 Facility number: 001198 Provider number: 155637 AIM number: 100471000 Survey team: Regina Sanders, RN- TC Sheila Sizemore, RN Kelly Sizemore, RN Census bed type: SNF: 26 SNF/NF: 115 Residential: 43 Total: 184 Census Payor Type: Medicare: 38 Medicaid: 79 Other: 67 Total: 184 Sample: 24 Supplemental sample: 13 Residential Sample: 7	F0000	N/A	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 25, 2011 by Bev Faulkner, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure a resident's physician was notified in a timely manner related to a high blood sugar, for 1 of 24 resident's reviewed for physician notification in a total sample of 24. (Resident #68)	F0157	F 1571. What is the corrective action taken for the resident found to be affected by the deficient practice? a. The Physician was notified related to Resident # 68 elevated blood sugar and no new orders received regarding the reported blood sugar.2. How other residents have the potential to be	03/25/2011

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	Findings include: 1. Resident #68's record was reviewed on 2/15/11 at 1 p.m. Resident #68's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and neurogenic bladder. A physician's recapitulation orders, dated 2/1/11 through 2/28/11, indicated Accucheck (blood sugar test) two times daily and Novolog (insulin) 100 units/milliliter injection sub-q (subcutaneous) per sliding scale (amount of insulin given based on blood sugar test): < (less than) 60=call MD; 60-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units, 301-350=8 units; 351-400=10 units; > (greater than) 400=12 units and call MD. A Glucose Monitoring Record, dated February 2011, indicated on 2/14 the 4 p.m. blood sugar result was 461. It indicated 12 units of Novolog insulin was given and the MD was not notified. A Medication Record, dated 2/1/11 through 2/28/11, indicated Accucheck (blood sugar test) two times daily and Novolog (insulin) 100 units/milliliter injection sub-q (subcutaneous) per sliding scale (amount of insulin given based on		affected by the same deficient practice will be identified and what corrective action will be taken. a. A chart audit was completed on all residents with orders for insulin coverage per sliding scale. The Physician was notified as indicated.3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. A re-in-service on Physician Notification Policy will be presented to Licensed staff b. A re-in-service will be presented to Licensed staff on Blood Sugar Policy /Sliding Scale Policy.4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. The medical records staff will audit blood sugar sliding scale documentation 3 days a week for one month, then weekly for 1 month, every other week for one month and then monthly for 3 months . The medical records staff will report audit findings to Director of Nursing who will present audit findings to Quality assurance monthly for six month. The quality assurance committee will review findings monthly for six month and will recommend whether monitoring needs to continue.	

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	blood sugar test): < (less than) 60=call MD; 60-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units, 301-350=8 units; 351-400=10 units; > (greater than) 400=12 units and call MD. The Medication Record lacked documentation of the MD being notified of the blood sugar >400. The resident's record lacked documentation of the MD being notified of the blood sugar greater than 400 on 02/14/11. A care plan, "Resident has Diabetes Mellitus," dated 1/25/11, indicated "...Notify MD with any abnormal blood sugar levels..." A facility policy titled "Change in Condition," dated May, 12,2008 and received as current by the DoN on 2/17/11 at 8:45 a.m., indicated "...Policy: It is the policy...that a licensed staff member will notify the attending physician...of change in the resident's condition..." During an interview with MDS Coordinator #5, on 2/16/11 at 10:15 a.m., she indicated the doctor should have been notified of blood sugar result of 461. 3.1-5(a)(2)			

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F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from abuse from a staff member, for 1 of 24 residents reviewed for abuse in a sample of 24. (Resident #22) Findings include: During an interview on 02/15/11 at 9:15 a.m., Resident #22 indicated she had no further problems with how the staff treats her. She indicated if she had problems she would tell the Social Service Director and she would take care of the problem for her. Resident #22's record was reviewed on 02/16/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and post right hip fracture. The resident was admitted into	F0223	F 2231. What is the corrective action taken for the resident found to be affected by the deficient practice? a. This was a self reported abuse allegation per ISDH abuse policy. A report sent 1/22/11 . The staff member, who was involved in this incident , is no longer employed at facility b. The resident was reassessed by therapy for mode of transfer which was then changed to a two person assist. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All alert an oriented resident were interviewed with no further allegation 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Abuse prevention re-in-service was presented to staff. c. Social Services will conduct follow-up	03/25/2011

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	the facility on 01/07/11. An admission Minimum Data Set Assessment, dated 01/17/11, indicated the resident could make her self understood and could understand others, and had a mental status summary score of 11 (moderately impaired), and required extensive assistance of two or more staff for bed mobility and transfers The Resident Assessment Protocol report, dated 01/17/11, indicated the resident needed assistance of two staff for bed mobility and transfers. A care plan, dated 01/07/11, indicated the resident had a history of a recent fall with a right hip fracture. The approaches included to transfer the resident with two assistance. A Physical Therapy evaluation note, dated 01/08/11, indicated the resident required maximum assistance with standing. A Nurses' Note, dated 01/22/11, no time documented, indicated, "Care Concern noted...Head to toes complete s/ (without) abnormal findings...Denies any pain or discomfort..." A facility, "Incident Reporting Form," dated 01/22/11, indicated the resident		interviews to assess resident's emotional well being 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. The Quality Assurance committee reviews all allegations of abuse monthly. Recommendations are discussed and follow-up as needed. This is an ongoing process.	

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	made an allegation of rough handling against former CNA #7. An investigation note, dated 01/22/11, indicated an Activities Aide went to the Director of Dietary (Manager on Duty) and informed her the resident indicated she had a bad experience with one of the CNA's this morning. The note from the Director of Dietary indicated, "...I went to speak with the resident and she stated that this morning, the girl that came in to help her was rude to her...The aide told her to get up for breakfast and the resident stated she needed help to do that and the aide said that she could stand by her self (sic) and didn't need any help. Resident got herself to sitting position...and then held on to the aides (sic) arm which at that point the aide pushed her hand off her arm. Resident was afraid of falling..." An investigation note, dated 01/22/11 at 1:50 p.m., indicated the Nurse Manager spoke with the resident and the resident identified former CNA #7 as the CNA who took care of her that morning. The note indicated former CNA #7 was removed from the unit. The note indicated the resident had told CNA #7 she could not stand and the CNA had told her she could. The note indicated the resident said, "...I could tell she didn't want too (sic) because she made a face,			

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	and was rough with my things...when it was time to get in to the wheel chair (sic) from the bed she said ok (resident name) stand up and she placed a hand under my arm and hoisted me up to a stand. It was then that my knees gave out and I grabbed her pant leg for support. She yelled at me to let go and slapped my hand off of her. This caused me to quickly sit in the wheel chair (sic) and I was so afraid I was going to fall and brake (sic) my hip again..." An investigation note, dated 01/22/11 at 11 a.m. from former CNA #7, indicated, "...she requested to get dress (sic) and up (arrow up) in the wheelchair at 11:00 a.m...I asked her to stand up (arrow up) for me and I told her I would be right here to assist her. I was standing on her left side and placed my left arm underneath her arm and said on the count of 3 we are going to stand up (arrow up). I counted to 3 and she stood up (arrow up). As I was pulling her pants up (arrow up), she was grabbing onto my uniform, extremely tight, making it difficult for me to assist her. I told (resident name) she is going to have to let go of my uniform, I never slapped, shoved, pushed or grabbed her hand at any point..." The completed investigation, dated 01/27/11, indicated, "...at end of investigation it was determined that there			

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	was no intent but the resident did appear to have some emotional stress immediately after incident...Certified Nursing Aide is no longer employed at facility. An abuse in-service is underway." A Social Service note, dated 01/26/11 at 9:45 a.m., indicated the resident had verbalized her concern about the CNA and the care. The note indicated the resident was comfortable and calm. A facility policy, titled, "Community Protocol for Abuse Prevention", dated 09/08, and received from the Executive Director as current, indicated, "It is the policy of this facility that each resident has the right not (sic) be subjected to abuse by anyone..." 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on observation, record review, and interview, the facility failed to thoroughly investigate and report to the Indiana State Department of Health, an injury of unknown origin related to multiple	F0225	F 2251. What is the corrective action taken for the resident found to be affected by the deficient practice? a. A head to toe assessment was completed on Resident #120 and it was	03/25/2011

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	bruising found on 1 of 24 residents reviewed for injuries of unknown origin in a sample of 24. (Resident #120) Findings include: Resident #120's record was reviewed on 2/16/11 at 2:35 p.m. Resident #120's diagnoses included, but were not limited to, dementia, seizure disorder, and arthritis. A quarterly MDS (Minimum Data Set) assessment, dated 11/12/10, indicated Resident #120 was cognitively impaired and required extensive assist for transfer, ambulation, and dressing. The assessment indicated the resident had previous falls in the facility. A Nurses' Note, dated 12/1/10 at 1:45 p.m., indicated "Summonsed to room c/ (with) CNA by resident's alarm. Res (resident) found on bathroom floor in front of sink sitting upright on buttocks c/ w/c (wheelchair) in front of her right past bathroom entryway. Res reports she had taken self to toilet. Denies c/o (complaint of), rom (range of motion) wnl (within normal limits) to all ex (extremities)...no evidence of injury noted...." A Nurses' Note, dated 12/1/10 at 7:00 p.m., indicated "No injuries noted		determined there was no further injury related to previous incident of multiple bruising. b. The fall committee will re-evaluate resident # 120 to determine safety issues and precautions. c. The care plan will be reviewed and updated related to falls ,syncope, dementia and toileting program will be assessed d. Social services will meet with family to initiate care plan intervention related to falls and declining dementia in order to manage safety issues. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All residents will be reassessed to determine if bruising and or skin issues are evident .Any bruising and or skin issues will be reported to attending physician and ISDH if appropriate. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Staff will be re-in-service on facility policies and procedures on thoroughly investigating and reporting on injuries of unknown origin. Staff will also be re-in-service to include initiating and completing facility incident and accident report. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a.	

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	post-fall. No bruising...." Nurses' Notes, dated 12/2/10 at 12 noon and 7:00 p.m., "...No injuries noted...." A Nurses' Note, dated 12/3/10 at 5:00 a.m., indicated "...o/ evidence of injury...." Nurses' Notes, dated 12/3/10 at 11:00 a.m. and 9:30 p.m., indicated the resident had no injury. A Nurses' Note, dated 12/4/10 at 11:00 a.m., indicated no injuries from the previous fall. A Nurses' Note, dated 12/7/10 at 1:15 a.m., indicated "Skin assessment: skin w/d (warm dry) touch. Pink color, no skin tears, no pressure sites." A Nurses' Notes, dated 12/14/10 at 7:00 a.m., indicated "The resident fell December 1st. Her skin assessment shows bruises, multiple R (right) hip 9 x (by) 9 cm (centimeters) greenish/purple. Bruise, R outter (sic) thigh green bruise 3 cm x 2 cm. R inner thigh prox (proximately) knees 3 x 3 cm green bruise. R lower outer leg 2 cm x 2 cm green bruise. L (left) shin 8 cm wide 6 cm long pale green bruise L lower leg 3 cm circle bruise. When resident asked where they came from she stated she fell...."		RCC/Designee will review Incident /Accident Report for completeness, witness statements, and detemined an investigation has been initiated/and or completed. b. Incidents /Accidents will be reviewed at the morning clinical meeting and it will be determined by Director of Nursing /Administrator if further action required. c. Director of Nursing /Designee will report Incident/Accident findings to Q/a monthly and this will be ongoing.	

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	This was 14 days after the resident fell on 12/1/10. The Skin and Shower Sheets, dated December and January 2011, lacked documentation of Resident #120 having any bruises. During an interview on 2/16/11 at 4:40 p.m., LPN #10 indicated the CNAs are supposed to document areas found on the resident "like bruises" on the Skin and Shower Sheets. The Investigation Conclusion Form, dated 12/1/10, indicated the resident did not receive any injuries from the fall. A form, dated 12/14/11 at 1:15 a.m., provided by the ADoN (Assistant Director of Nursing) on 2/17/11 at 2:15 p.m., titled "Accident Incident Report" indicated the bruising on the resident was found during rounds by the nurse. The form indicated the one witness the facility asked had not been taking care of the resident. Resident #120 was observed on 2/16/11 at 3:55 p.m. CNA #6 was assisting the resident to the bathroom. The resident was observed to have very faint green bruising to the right hip and the thigh. CNA #6 indicated she was off the day the resident fell. CNA #6 indicated the			

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	resident had fallen twice that week. During a interview on 2/16/11 at 3:20 p.m., the Eden Unit Manager indicated the nurses do a narrative skin assessment weekly in the nurses' notes. During an interview on 2/16/11 at 3:25 p.m., the Restorative Nurse indicated the resident did not have any bruising when she fell on 12/1/10. When asked about the resident's bruising the Restorative Nurse indicated she did know how the resident acquired the bruising. During an interview on 2/16/11 at 3:40 p.m., the Restorative Nurse indicated the facility could not find an unusual occurrence for 12/14/11. During an interview on 2/17/11 at 10:05 a.m., RN #4 indicated she was the nurse who found the bruises on Resident #120 on 12/14/10. RN #4 indicated she did not know how the bruising occurred or if the resident had fallen. RN #4 indicated she worked the midnight shift and does not "see the residents below the waist, just the arms." RN #4 indicated she did not know why the CNAs did not report the resident's bruising. RN #4 indicated she had filled out an incident report but management could not find it and had just came and talked to her about it. RN #4			

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	155637	A. BUILDING 00 B. WING	02/23/2011

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	indicated the bruises had looked like the resident had "bumped everything in the bathroom." RN #4 indicated the resident would not be able to get up on her own if she fell. During an interview on 2/17/11 at 2:10 p.m., the ADoN indicated there was only one witness statement. The ADoN indicated the incident had not been investigated nor reported to the Indiana State Department of Health. 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview, the facility failed to follow the facility's policy for investigating and reporting to the Indiana State Department of Health an unusual occurrence related to	F0226	F2261. What is the corrective action taken for the resident found to be affected by the deficient practice? a. A head to toe assessment was completed on Resident #120 and it was	03/25/2011

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	injuries of unknown origin for 1 of 24 residents reviewed for injuries of unknown origin in a sample of 24 residents. (Resident #120) Findings include: A facility policy titled "Accidents and Incidents," dated 2/10, indicated "Investigation Process: All incidents require a thorough investigation in an attempt to determine what occurred and to make changes as needed to prevent reoccurrence...The investigation seeks to determine if and how abuse, neglect, negligent treatment, exploitation, or misappropriation of resident property occurred...Reporting to State Regulatory Agency: ...2. When an incident /accident is reportable, initial notification to public health will be made within 24 hours of the incident/accident...." Resident #120's record was reviewed on 2/16/11 at 2:35 p.m. Resident #120's diagnoses included, but were not limited to, dementia, seizure disorder, and arthritis. A quarterly MDS (Minimum Data Set) assessment, dated 11/12/10, indicated Resident #120 was cognitively impaired and required extensive assist for transfer, ambulation, and dressing. The assessment		determined there was no further injury related to previous incident of multiple bruising. b. A Complete an thorough investigation related to injury of unknown origin will be submitted to ISDH c. The fall committee will re-evaluate resident # 120 to determine safety issues and precautions. d. The care plan will be reviewed and updated related to falls ,syncope, dementia and toileting program will be assessed e. Social services will meet with family to initiate care plan intervention related to falls and declining dementia in order to manage safety issues. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All residents will be reassessed to determine if bruising and or skin issues are evident .Any bruising and or skin issues will be reported to attending physician and ISDH if appropriate. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Staff will be re-in-service on facility policies and procedures on thoroughly investigating and reporting on injuries of unknown origin. Staff will also be re-in-service to include initiating and completing facility incident and accident report. 4. How the corrective	

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	indicated the resident had previous falls in the facility. A Nurses' Note, dated 12/1/10 at 1:45 p.m., indicated "Summonsed to room c/ (with) CNA by resident's alarm. Res (resident) found on bathroom floor in front of sink sitting upright on buttocks c/ w/c (wheelchair) in front of her right past bathroom entryway. Res reports she had taken self to toilet. Denies c/o (complaint of), rom (range of motion) wnl (within normal limits) to all ex (extremities)...no evidence of injury noted...." A Nurses' Note, dated 12/1/10 at 7:00 p.m., indicated "No injuries noted post-fall. No bruising...." Nurses' Notes, dated 12/2/10 at 12 noon and 7:00 p.m., "...No injuries noted...." A Nurses' Note, dated 12/3/10 at 5:00 a.m., indicated "...o/ evidence of injury...." Nurses' Notes, dated 12/3/10 at 11:00 a.m. and 9:30 p.m., indicated the resident had no injury. A Nurses' Note, dated 12/4/10 at 11:00 a.m., indicated no injuries from the previous fall. A Nurses' Note, dated 12/7/10 at 1:15		actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. RCC/Designee will review Incident /Accident Report for completeness, witness statements, and investigation has been initiates/and or completed. b. Incidents /Accidents will be reviewed at morning clinical meeting and it will be determined by Director of Nursing /Administrator if further action required. c. Director of Nursing /Designee will report Incident/Accident findings to Q/a monthly and this will be ongoing.	

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a.m., indicated "Skin assessment: skin w/d (warm dry) touch. Pink color, no skin tears, no pressure sites."

A Nurses' Notes, dated 12/14/10 at 7:00 a.m., indicated "The resident fell December 1st. Her skin assessment shows bruises, multiple R (right) hip 9 x (by) 9 cm (centimeters) greenish/purple. Bruise, R outter (sic) thigh green bruise 3 cm x 2 cm. R inner thigh prox (proximately) knees 3 x 3 cm green bruise. R lower outer leg 2 cm x 2 cm green bruise. L (left) shin 8 cm wide 6 cm long pale green bruise L lower leg 3 cm circle bruise. When resident asked where they came from she stated she fell...." This was 14 days after the resident fell on 12/1/10.

The Skin and Shower Sheets, dated December and January 2011, lacked documentation of Resident #120 having any bruises.

During an interview on 2/16/11 at 4:40 p.m., LPN #10 indicated the CNA's are suppose to document areas found on the resident "like bruises" on the Skin and Shower Sheets.

The Investigation Conclusion Form, dated 12/1/10, indicated the resident did not receive any injuries from the fall.

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	A form, dated 12/14/11 at 1:15 a.m., provided by the ADoN (Assistant Director of Nursing) on 2/17/11 at 2:15 p.m., titled "Accident Incident Report" indicated the bruising on the resident was found during rounds by the nurse. The form indicated the one witness the facility asked had not been taking care of the resident. Resident #120 was observed on 2/16/11 at 3:55 p.m. CNA #6 was assisting the resident to the bathroom. The resident was observed to have very faint green bruising to the right hip and the thigh. CNA #6 indicated she was off the day the resident fell. CNA #6 indicated the resident had fallen twice that week. During a interview on 2/16/11 at 3:20 p.m., the Eden Unit Manager indicated the nurses do a narrative skin assessment weekly in the nurses' notes. During an interview on 2/16/11 at 3:25 p.m., the Restorative Nurse indicated the resident did not have any bruising when she fell on 12/1/10. When asked about the resident's bruising the Restorative Nurse indicated she did know how the resident acquired the bruising. During an interview on 2/16/11 at 3:40 p.m., the Restorative Nurse indicated the facility could not find an unusual			

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	occurrence for 12/14/11. During an interview on 2/17/11 at 10:05 a.m., RN #4 indicated she was the nurse who found the bruises on Resident #120 on 12/14/10. RN #4 indicated she did not know how the bruising occurred or if the resident had fallen. RN #4 indicated she worked the midnight shift and does not "see the residents below the waist, just the arms." RN #4 indicated she did not know why the CNAs did not report the resident's bruising. RN #4 indicated she had filled out an incident report but management could not find it and had just came and talked to her about it. RN #4 indicated the bruises had looked like the resident had "bumped everything in the bathroom." RN #4 indicated the resident would not be able to get up on her own if she fell. During an interview on 2/17/11 at 2:10 p.m., the ADoN indicated there was only one witness statement. The ADoN indicated the incident had not been investigated nor reported to the Indiana State Department of Health according to facility policy. 3.1-38(a)			

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F0272 SS=E	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, record review, and interview, the facility failed to ensure assessments were complete and accurate related to bruising, fall risk assessment, bladder, and a PICC (peripherally inserted central catheter) line for 4 of 24 residents reviewed for complete and accurate assessments in a sample of 24 residents.	F0272	F 2721. What is the corrective action taken for the resident found to be affected by the deficient practice? a. A head to toe assessment was completed on resident #120.The assessment indicated that this resident had no further bruising, This assessment has been documented in the nurses notes	03/25/2011

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	(Resident #22, #23, #38, and #120) Findings include: 1. Resident #120's record was reviewed on 2/16/11 at 2:35 p.m. Resident #120's diagnoses included, but were not limited to, dementia, seizure disorder, and arthritis. A quarterly MDS (Minimum Data Set) assessment, dated 11/12/10, indicated Resident #120 was cognitively impaired and required extensive assist for transfer, ambulation, and dressing. The assessment indicated the resident had previous falls in the facility. A Nurses' Note, dated 12/1/10 at 1:45 p.m., indicated "Summonsed to room c/ (with) CNA by resident's alarm. Res (resident) found on bathroom floor in front of sink sitting upright on buttocks c/ w/c (wheelchair) in front of her right past bathroom entryway. Res reports she had taken self to toilet. Denies c/o (complaint of), rom (range of motion) wnl (within normal limits) to all ex (extremities)...no evidence of injury noted...." A Nurses' Note, dated 12/1/10 at 7:00 p.m., indicated "No injuries noted post-fall. No bruising...."		and the resident care plan and aide care record have been updated . b. The PICC site for resident # 23 was assessed following facility policy and procedure. The findings of the assessment were documented in resident clinical record. Resident care plan and aide care record sheet have been updated. c. The fall assessment for resident # 38 was reviewed and updated to indicate residents current fall status .Residents care plan and aide care record sheet have been updated. d. Resident #22 i. The fall assessment for resident #22 was reviewed and corrected to reflect the residents current fall status. Resident fall risk assessment indicates resident is at high risk for falls with a score of 12. The care plan and aide assignment sheet have been updated to reflect residents current fall status. ii. Resident # 22 was reassessed related to contingency on 2/16/11 and documented on urinary assessment form. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All residents will be reassessed for skin issues, falls and incontinence. Findings will be documented in medical record , care plan and aide care record sheets will updated as needed b. All resident with PICC lines will be reassessed per facility PICC	

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	Nurses' Notes, dated 12/2/10 at 12 noon and 7:00 p.m., "...No injuries noted...." A Nurses' Note, dated 12/3/10 at 5:00 a.m., indicated "...o/ evidence of injury...." Nurses' Notes, dated 12/3/10 at 11:00 a.m. and 9:30 p.m., indicated the resident had no injury. A Nurses' Note, dated 12/4/10 at 11:00 a.m., indicated no injuries fro the previous fall. A Nurses' Note, dated 12/7/10 at 1:15 a.m., indicated "Skin assessment: skin w/d (warm dry) touch. Pink color, no skin tears, no pressure sites." A Nurses' Notes, dated 12/14/10 at 7:00 a.m., indicated "The resident fell December 1st. Her skin assessment shows bruises, multiple R (right) hip 9 x (by) 9 cm (centimeters) greenish/purple. Bruise, R outter (sic) thigh green bruise 3 cm x 2 cm. R inner thigh prox (proximately) knees 3 x 3 cm green bruise. R lower outer leg 2 cm x 2 cm green bruise. L (left) shin 8 cm wide 6 cm long pale green bruise L lower leg 3 cm circle bruise. When resident asked where they came from she stated she fell...." This was 14 days after the resident fell on 12/1/10. A green bruise in an indication of an		policy and procedure and findings documented in the medical record. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. MDS team will be re-in-serviced with emphasis on i. Assessment Protocol ii. Accuracy and completeness of assessment iii. Care Plan/Aide care record 1. Initiate /updates 2. Complete /Accurate b. Licensed nurses will be re-in-service on PICC protocol 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. All MDS/Care plans that are scheduled be completed during month will be audited by consultant nurse /designee monthly for six months. Findings will be reviewed by Director of Nursing who will report to Q/A if trends are identified audits will be ongoing until compliance is reached.	

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	older/healing bruise. A Professional Resource Website, "www.nlm.nih.gov" (National Library of Medicine and National Institute of Health), titled, "Bruise Mark Treatment", dated 07/09, indicated, "...The bruise will change color from red to purple to yellow to brown before disappearing..." The Skin and Shower Sheets, dated December and January 2011, lacked documentation of Resident #120 having any bruises. The Investigation Conclusion Form, dated 12/1/10, indicated the resident did not receive any injuries from the fall. Resident #120 was observed on 2/16/11 at #:55 p.m. CNA #6 was assisting the resident to the bathroom. The resident was observed to have very faint green bruising to the right hip and the thigh. CNA #6 indicated she was off the day the resident fell. CNA #6 indicated the resident had fallen twice that week. During a interview on 2/16/11 at 3:20 p.m., the Eden Unit Manager indicated she did not know why the bruises were not documented in the skin assessments. The Eden Unit Manager indicated the nurses do a narrative skin assessment			

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	weekly in the nurses' notes. During an interview on 2/16/11 at 3:25 p.m., the Restorative Nurse indicated the resident did not have any bruising when she fell on 12/1/10. When asked about the resident's bruising the Restorative Nurse indicated she did not know how the resident acquired the bruising. During an interview on 02/16/11 at 3:35 p.m., the Restorative Nurse indicated a green bruise was an old bruise. She indicated she did not think the bruises were from the fall on 12/01/10. 2. During an observation on 02/15/11 at 9 a.m., Resident #23 was sitting in a wheelchair in his room. There was a PICC line located in the resident's left arm. Resident #23's record was reviewed on 02/15/11 at 11 a.m. The resident's diagnoses included, but were not limited to, renal insufficiency and Parkinson's Disease. A Physician's Recapitulation order, dated 02/11, indicated the resident had a PICC line in the left arm since 12/10/10 and the facility was to change the dressing on the PICC line every seven days. A Physician's Order, dated 01/28/11,			

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	indicated an order for Zosyn (antibiotic), to be administered by the PICC line every six hours. The resident's Treatment Administration Record (TAR), dated 01/11, indicated the resident's PICC line was flushed daily for maintenance. The resident's TAR and Medication Administration Records (MAR), dated 01/11 and 02/11, and the Nurses' Notes, dated 01/02/11 through 02/15/11, lacked documentation to indicate the PICC line, the arm circumference, and the PICC line measurement had been assessed as indicated in the facility policy. During an interview on 02/15/11 at 1:05 p.m., LPN #2 indicated there was no documentation to indicate the PICC line had been assessed. A facility policy, dated 03/07, titled, "Peripherally Inserted Central Catheter (PICC) Dressing Change", received from the Director of Nursing as current, indicated, "...5. Assessment of venous access site is performed: 5.1 During dressing changes...5.3 Before and after administration of intermittent infusions, 5.4 At least once every shift when not in use. 6. Assessment is to include, but is not limited to, the absence or presence of: 6.1 erythema, 6.2 Drainage, 6.3 Swelling or induration, 6.4 Change in skin temperature, 6.5 Tenderness at the site or along vein tract, 6.6 Integrity of transparent dressing. 7. Length of externa catheter and upper arm circumference...is obtained:...7.2 During dressing changes..."			

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3. Resident #38's record was reviewed on 02/17/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension.

The resident's, Fall Risk Assessment, dated 10/26/10, 01/04/11, 01/21/11, and 02/03/11, indicated the resident had fallen in the past three months.

The resident's Nurses' Notes, dated 01/04/11 through 02/17/11, lacked documentation to indicate the resident had a fall.

During an interview on 02/17/11 at 10:50 a.m., the Reclaim Unit Manager, indicated the resident had not had a fall since 04/06/10. She indicated the fall assessment was not correct.

4. Resident #22's record was reviewed on 02/16/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and post right hip fracture. The resident was admitted into the facility on 01/07/11.

A) The Fall Risk Assessment, dated 01/07/11, indicated the resident was on an antihypertensive (Lopressor), a diuretic (Lasix), and a narcotic (Oxycontin) and the score for the medication area was three and the resident had no fractures. The total score on the Fall Risk Assessment was 9 (total score of 10 or above represents a high risk for falls).

The Fall Risk Assessment indicated if the resident takes three to four of the medications, the resident's score would be a four, and if the resident's fracture would have been marked, the score would have been two, which would make the

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	resident's total score a 12, placing the resident at a high risk for falls. During an interview on 02/16/11 at 10:40 a.m., the Reclaim Unit Manager, indicated the score on the Fall Assessment Risk should have been a four, not a three for the medications and the resident's hip fracture should have been marked, which would have made the resident's total score a 12 and placed the resident at a high risk for falls. B) The resident's Urinary Incontinence Assessment, dated 01/11/11 indicated the resident was continent of bowel and bladder. The 3-Day Bladder Data Collection record, dated 01/08/11, 01/09/11, and 01/10/11 indicated the resident was incontinent frequently. During an interview on 02/16/11 at 10:30 a.m., Minimum Data Set (MDS) Nurse #3, indicated the resident had been frequently incontinent, but had improved on the 14 day MDS assessment. She indicated she was unsure why the nurse indicated the resident was continent when the resident was frequently incontinent at the time of the assessment. She indicated the bladder assessment was to be completed after the three day voiding pattern was completed. She indicated the bladder assessment was incorrect. 3.1-31(a)			

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F0278 SS=A	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure MDS (Minimum Data Set) Assessments were completed accurately, related to missed diagnoses and pain management, for 3 of 24 residents reviewed for accuracy of MDS's in a sample of 24. (Resident's #66, #94, #141)	F0278	F 2781. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident # 66 MDS has been correct to reflect diagnosis of depression b. Resident # 94 MDS has been correct to reflect diagnosis neurogenic bladder c. Resident # 141 MDS has been corrected to reflect that resident is receiving	03/25/2011

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	Findings include: 1. Resident #66's record was reviewed on 2/18/11 at 9:30 a.m. Resident #66's diagnoses included, but were not limited to, hypertension, osteoarthritis, congestive heart failure, and depression. A Physician's Recapitulation Orders, dated 12/1/10 through 12/31/10, indicated the resident had an order for Zoloft and a diagnosis of depression. A Quarterly Minimum Data Set (MDS) Assessment, dated 12/09/10, indicated the resident received an antidepressant during the last 7 days or since admission/reentry if less than 7 days. The MDS lacked depression as an active diagnosis in the last 7 days. During an interview with MDS Coordinator #3, on 2/18/11 at 10:20 a.m., she indicated depression should have been checked on the MDS. 2. Resident #94's record was reviewed on 2/15/11 at 9:05 a.m. Resident #94's diagnoses included, but were not limited to, diabetes, hypertension, cardiovascular accident (CVA, stroke), and neurogenic bladder. A CAA (Care Area Assessment), dated		pain management 2. How other residents who have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. The resident's current MDS 's will be reviewed by the MDS nursing staff to ensure that diagnosis and pain management is coded correctly. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. MDS team will be re-in-serviced with emphasis on i. Assessment Protocol ii. Accuracy and completeness of assessment 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. MDS/Care plans that are scheduled to be completed during month will be audited by consultant nurse /designee monthly for six months. Findings will be reviewed by Director of Nursing who will report to Q/A if trends are identified audits will be ongoing until compliance is reached.	

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	11/14/10, indicated "...has a dx (diagnosis) of neurogenic bladder..." An Admission MDS, dated 11/17/10, lacked neurogenic bladder as an active diagnosis. During an interview with MDS Coordinator #3, on 2/15/11 at 11:15 a.m., she indicated the neurogenic bladder diagnosis must have been missed. 3. Resident #141's record was reviewed on 2/16/11 at 11:20 a.m. Resident #141's diagnoses included, but were not limited to congestive heart failure, hypertension, and dementia. A physician's order, dated 8/26/10, indicated "APAP/COD #3 (narcotic pain reliever) one tablet twice daily." A significant change MDS (Minimum Data Set) assessment, dated 11/26/10, indicated Resident #141 was not receiving a scheduled pain management regimen. During an interview on 2/16/11 at 12:17 p.m., the Wound Care Nurse indicated the MDS assessment was wrong as the resident was on schedule pain management. 3.1-31(d)			

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F0280 SS=E	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure resident's care plans were developed and updated, related to dental, restraints, dehydration, TED (support) hose, activities, and cognitions status for 5 of 24 residents reviewed for care plans in a sample of 24. (Residents #10, #22, #98, #125, and #141) Findings include: 1. Resident #22's record was reviewed on 02/16/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and post right hip fracture. The resident was admitted into	F0280	F Tag 280 1. What is the corrective action taken for the resident found to be affected by the deficient practice? a. The care plan for Resident # 22 was reassessed related to cognitive status and activities .The resident care plan has been updated to reflect cognitive and activity status . b. The care plan for resident # 10 was reviewed and TED hose was discontinued from care plan. c. The care plan for resident # 125 was reviewed and updated to reflect self releasing belt which now is identified as a restraint. d. Resident #141 was reassessed and care plan reviewed and updated to reflect the resident to	03/25/2011

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	the facility on 01/07/11. The resident's Care Area Assessment (CAA) Summary, dated 01/20/11, indicated the resident triggered activities and cognitive loss/dementia. The CAA indicated the facility was going to proceed with a care plan for both areas. The resident's care plan, dated 01/27/11, lacked documentation of a care plan for the resident's cognitive loss/dementia and activities. During an interview on 02/16/11 at 10:30 a.m., Minimum Data Set (MDS) Nurse #3 indicated there were no care plans for the resident's cognition and activities. 2. Resident #10's record was reviewed on 02/15/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus. The resident's care plan, dated 12/15/10, indicated the resident had edema of the bilateral lower extremities. The approaches included to apply TED (support) hose as ordered. The Physician's Recapitulation Orders, dated 02/11, lacked documentation to indicate the resident had an order for TED hose.		be at risk for dehydration e. The care plan for resident # 98 was reviewed and updated to reflect assist bid with oral hygiene. 2. How other residents who have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. The MDS team will reviewed all resident care plans to ensure that they accurately reflect current status of resident. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur i. Assessment Protocol ii. Accuracy and completeness of assessment iii. Developing care plans from assessments 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. All Care plans that are scheduled to be completed during month will be audited by consultant nurse /designee monthly for six months. Findings will be reviewed by Director of Nursing who will report to Q/A if trends are identified audits will be ongoing until compliance is reached.	

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During on interview on 02/15/11 at 10:35 a.m., MDS nurse #5 indicated there was no order for TED hose. She indicated they were preprinted care plans and had not been revised it for the resident.
3. Resident #125's record was reviewed on 2/17/11 at 10:20 a.m. Resident #125's diagnoses included, but was not limited to dementia, cerebral vascular accident (stroke) and osteoporosis.

A quarterly MDS (Minimum Data Set) assessment, dated 12/17/10, indicated Resident #125 was cognitively impaired. The quarterly MDS assessment indicated the resident required extensive assist for transfer, dressing, and hygiene. The quarterly MDS assessment was not marked for a restraint.

A Restraint Release Form, dated 1/24/11, indicated the resident was unable to release the self release lap belt on command and the facility would "now consider this a restraint."

Resident #125's care plans, dated 7/1/10 and revised 12/21/10, lacked documentation of a care plan for the resident's self release lap belt. A fall care plan, dated 7/1/10 and revised 12/21/10, indicated 9/14/10, self release alarming belt in wheelchair. There was a lack of

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	documentation to indicate to staff, interventions to be used now that the self release lap belt was a restraint. During an interview on 2/17/11 at 11:05 a.m., the Restorative Nurse indicated there was not a care plan completed for the self releasing seat belt now that it was considered a restraint. 4. Resident #141's record was reviewed on 2/16/11 at 11:20 a.m. Resident #141's diagnoses included, but were not limited to congestive heart failure, hypertension, and dementia. A significant change MDS (Minimum Data Set) assessment, dated 11/26/10, indicated the CAA (Care Area Assessment) Summary indicated the facility would proceed to care plan Resident #141 for dehydration. Resident #141's care plans, dated 6/23/10 and revised 12/14/10, lacked documentation of a care plan for dehydration. During an interview on 2/16/11 at 12:20 p.m., the Wound Nurse indicated there was not a care plan for dehydration for Resident #141. 5. Resident #98's record was reviewed on			

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	2/15/11 at 9:13 a.m. Resident # 98's diagnoses included, but were not limited to, end stage renal, anemia, and diabetes. A Dentist Progress Note, dated 2/1/11, indicated "...Oral hygiene HORRIBLE! 2-3 mm (millimeters) of generalized plague...Patient needs assistance with brushing her teeth twice daily...." Residents #98's care plans, dated 1/1/11, lacked documentation of a care plan for the resident's oral hygiene. During an interview on 2/15/11 at 10:15 a.m., LPN #11 indicated the resident did not have a dental care plan. 3.1-35(c)(1) 3.1-35(d)(2)(B)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview and record review, the facility failed to meet professional standards of quality, related to a QMA (QMA #12) administering a	F0281	F 2811. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident # 125 was reassessed for pain on 2/16/11 related to QMA	03/25/2011

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	PRN (as needed) pain medication to a resident without the a nurse assessing the resident or authorizing the PRN pain medication to be administered for 1 of 24 residents with pain medications in a sample of 24. (Resident #125 and QMA #12) Findings include: QMA #12 was observed on 2/16/11 at 12:40 p.m., to remove Resident #125 from the dining room and take the resident to the nurses' station. QMA #12 was observed to administer 650 milligrams of Tylenol (pain reliever) to Resident #125. The QMA was not observed to tell a nurse of the resident's complaint of pain. During an interview on 2/16/11 at the time of the observation, QMA #12 indicated she did not tell a nurse of the resident's complaints of pain. During an interview on 2/16/11 at 12:45 p.m., MDS (Minimum Data Set) Coordinator #5 indicated the QMA was supposed to ask the nurses, so the nurses could assess the resident prior to giving the prn medication. A professional resource, titled, "QMA Scope of Practice: 412 IAC 2-1-9, reviewed on 02/22/11 at 9 a.m., indicated, "...11) administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty..." 3.1-35(g)(1)		administration of 650 mg of Tylenol a prn medication. b. QMA # 12 was counseled on the administration of prn medication 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. The problem was not related to other residents but to this QMA not foloowing policy and procedure.This concern wil lbe addressed with all QMA's related to prn medication administration.3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. All licensed staff will be re-educated as to role of QMA related to prn medication and their responsibility of overseeing QMA medication pass. b. All QMA were given a policy on prn medication administration c. All QMA were re-educated on their scope of practice related to prn medication 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. Rcc/Designee will conduct a weekly medication pass for one month then bi weekly for one month and monthly for 4 month. These audits will be conductedd on all shifts. Results of the observations will be reviewed by the Director of Nursing and trends will be	

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			reported to Q/A monthly for six months and on going if necessary.	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician's orders were followed, related to medications, and laboratory tests for 3 of 24 residents in a sample of 24 reviewed for following physician's orders. (Residents #10, #23, and #94) Findings include: 1. Resident #10's record was reviewed on 02/15/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus. The Physician's Recapitulation Orders, dated 02/11, indicated an order, originally dated 10/11/10, for Novolin (insulin) R to be given per sliding scale at 6 a.m., 11 a.m., and 4 p.m. daily. The order indicated for a blood sugar of 100-150 give 4 units of insulin and 151-200 give 6 units of insulin. The resident's Glucose Monitoring Record, indicated on 02/08/11 at 4 p.m., the resident's blood sugar was 120 and a line was drawn through the area for the	F0282	F Tag 282 1. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident # 10 -The physician was notified on 2/15/11 that insulin was not administered as ordered, resident had no adverse reaction and no new orders received. b. Resident #23 -The renal functions were not performed as ordered, physician was notified and test was performed on 2/16/11. c. Resident #94 -The medications (Prostat and Multi Vitaman)where not being administered per physician ordered.The Physician was notified on 2/17/11 and new orders received. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. A chart audit was completed on all residents with orders for insulin coverage per sliding scale. Physician was notified if findings indicated. b. All Residents charts will be audited for lab orders and those results are present and physician notified. c. All residents' physician orders will be audited for accuracy and completeness and MAR and TAR reviewed to	03/25/2011

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	insulin dose given. The form indicated on 02/10/11 at 4 p.m., the resident's blood sugar was 111 and a line was drawn through the area for the insulin dose give. The form indicated on 02/14/11 at 11 a.m., the resident's blood sugar was 193 and 4 units of insulin was given. The resident's Medication Administration Record (MAR), dated 02/11, indicated on 02/08/11 at 4 p.m., the resident did not receive insulin (circle around initials), there was a lack of documentation on the MAR to indicate the resident received 4 units of insulin on 02/10/11 at 4 p.m. During an interview on 02/15/11 at 10:50 a.m., the Reclaim Unit Manager indicated the insulins were not given as ordered. During this interview, RN #8, the nurse on duty on 02/10/11 at 4 p.m., indicated she had not given the insulin as ordered. 2. Resident #23's record was reviewed on 02/15/11 at 11 a.m. The resident's diagnoses included, but were not limited to, renal insufficiency and Parkinson's Disease. A Physician's Order, dated 01/28/11 at 4 p.m., indicated an order for renal function studies every three days. The resident's record indicated the last renal function in the resident's record was on 02/07/11. During an interview on 02/15/11 at 1:15 p.m.,		ensure they match physician orders. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. A re-in-service on Physician Orders and following physician orders b. A re-in-service will be presented to Licensed staff on Blood Sugar Policy /Sliding Scale Policy c. A re-in-service on lab ordering and following lab orders 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. Medical records will audit blood sugar sliding scale documentation 3 days a week for one month, then weekly for 1 month, every other week for one month and then monthly for 3 months . Medical records will report findings to Director of Nursing who will then report Quality assurance monthly. Quality assurance committee will review findings monthly for six month and will recommend whether monitoring needs to continue. b. RCC/designee will audit lab book daily and check medical record to ensure report is present and physician has been notified daily for one month .three times a week for one month, weekly for one month, every other week for one month and monthly for two months .Audit finds will be presented to Director of Nursing when completed and the Director	

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	LPN #2 indicated the resident should have had the renal function studies done on 02/10/11 and 02/13/11. She indicated she called the lab company, and they were faxing over the lab from 02/10/11, but they did not draw the renal function studies on 02/13/11. She indicated 02/13/11 was on a week-end and the nurse who was working was suppose to call the lab, and the nurse did not call, so the lab did not know they were suppose to draw the renal function test. 3. Resident #94's record was reviewed on 2/15/11 at 9:05 a.m. Resident #94's diagnoses included, but were not limited to, diabetes, hypertension, cardiovascular accident (CVA, stroke), and neurogenic bladder. A Physician's Order, dated 2/11/11 at 4:45 p.m., indicated Prostat (supplement) 30 milliliters twice a day and change MVI (multivitamin, supplement) to MVI with minerals. A Medication Record, dated 2/1/11 through 2/28/11, indicated Multivitamin liquid 5 cc (cubic centimeters) per g-tube (feeding tube) qd (everyday) and was initialed as given on 2/12, 2/13, 2/14 and 2/15. (This was not the multivitamin with minerals.) The Medication Record and Treatment Record, dated 2/1/11 through 2/28/11, lacked documentation the Prostat was		of nursing will report findings to the Q/A monthly for six month. c. All residents' physician orders will be audited monthly for accuracy and completeness and MAR and TAR reviewed to ensure they match physician orders. Audit reports will be presented to Director of Nursing who will present findings to Q/A monthly for six month. If indicated audits will be ongoing	

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	ever given. During an interview with LPN #9, on 2/15/11 at 10:45 a.m., she indicated the Prostat and MVI with minerals was not being given as ordered. 3.1-35(g)(2)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review and interview, the facility failed to assist a resident who was unable to perform ADLs (activities of daily living) for 1 of 24 residents who required assistance with oral hygiene in a sample of 24 residents. (Resident #98) Findings include: Resident #98's record was reviewed on 2/15/11 at 9:13 a.m. Resident # 98's diagnoses included, but were not limited to, legally blind, end stage renal, anemia, and diabetes. An annual MDS (Minimum Data Set), dated 1/7/11, indicated the resident's cognition was intact, but required extensive assist of one staff for personal	F0312	F 3121. What is the corrective action taken for the resident found to be affected by the deficient practice? a. An oral assessment for resident #98 was completed by the dentist on 2/01/11.The dentist recommendedin progress notes that resident was to receive assistance with brushing teeth twice daily. A new toothbrush and toothpaste was dispensed. Certified Nursing Assistant Care Record was updated 2/15/11 it reflected dentist recommendation and care plan was updated on 2/15/11 to indicate assist with oral hygiene twice daily. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident will be	03/25/2011

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	hygiene, transfers, and toilet use. A Dentist Progress Note, dated 2/1/11, indicated "...Oral hygiene HORRIBLE! 2-3 mm (millimeters) of generalized plague...Patient needs assistance with brushing her teeth twice daily...." Residents #98's care plans, dated 1/1/11, lacked documentation of a care plan for the resident's oral hygiene with interventions for the staff to assist the resident in brushing her teeth. During an interview on 2/15/11 at 10:15 a.m., LPN #11 indicated the resident did not have a dental care plan. An undated CNA Care Record, provided on 2/15/11 at 10:15 a.m., by LPN #9 as current, indicated the resident required supervision and set up. During an interview at the above time with LPN #9, she indicated the resident required assistance with her ADLs. During an interview on 2/16/11 at 12:26 p.m., Resident #98 indicated "The CNAs helped me brush my teeth this morning, first time they helped me brush my teeth was this morning." A facility policy, dated 6/2/9, titled "Oral Hygiene" indicated "It is the policy of		reassessed for oral care to determine if assistance is needed. Toothbrushes are replaced every thirty days. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. A meeting with dentist will be scheduled to discuss improving assessment communication related to oral hygiene. b. Nursing staff will be re-in-serviced on oral care assessment and procedure c. It will be documented on the aide assignment sheet if resident needs assistance with oral care and frequency. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. A follow up meeting will be scheduled with the dentist to review changes in procedure that dentist will document recommendation on physician order sheet rather then in progress notes. The nurse wil lbe responsible to note and imp[lement physician orders as documented on ophysician order sheet. b. Oral assessment are done daily by certified nursing aide .An oral assessment will be completed monthly by licsened nursing staff who will document and report abnormal findings in nurses notes. RCC/Designee will audit monthly oral documentation for six months and will provide	

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	Christian Home, Inc. to ensure oral care is completed either by the resident or by staff members...." 3.1-38(a)(3)(C) 3.1-38(b)(1)		Director of Nursing for six months and Director of Nursing will report findings to Q/A for six month.	
F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review and interview, the facility failed to ensure a resident with a gastrostomy tube (g-tube) (feeding tube) received appropriate treatment related to checking the g-tube for placement and purging	F0322	F 3221. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident # 74 was assessed to determine that she had no ill effects as a result of lack of checking g- tube placement prior to administering medication. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All current g-tube residents have been identified an	03/25/2011

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	medications and fluids into the g-tube for 1 of 2 residents reviewed with gastric tubes in a sample of 24. (Resident #74) Findings include: During an observation of the morning medication pass on 02/15/11 at 7:10 a.m., RN # 4 prepared Resident #74's medication. RN #4 then entered the resident's room flushed the g-tube with 60 cc's (cubic centimeters) by purging (forcing-not allowing flow by gravity) the water into the tube. RN #4 did not check the g-tube for placement prior to purging the water. RN #4 then continued to purge the resident's liquid potassium, followed by purging 60 cc of water, then purged the resident's acidophilus		re-assessed and licensed nursing staff have been re-educated to g-tube policy and procedure. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. All licensed staff will be re-in-serviced on g-tube policy and procedure and will need to pass g-tube competency demonstration. b. All licensed staff will be re-evaluated yearly to ensure that g-tube policy and procedure are followed and competency demonstration is passed. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place. a. RCC/Designee will observe 3 monthly random g-tube medicaiton passess.The medication passess will occur on each shift for six months. RCC/Designees will report monthly findings to Director of Nursing.The Director of Nursing will report findings to Q/A for six month.	

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	(probiotic) mixed with water, followed by purging 60 cc's of water. RN #4 then purged 300 cc's of water for the ordered flush of the g-tube. During an interview on 02/15/11 at 7:20 a.m., RN #4 indicated she only checks g-tube placements once a shift and she had done that at the beginning of her shift (worked night shift). She indicated they could purge the medications and fluids into the g-tube. A facility policy, dated 07/05, titled, "Tube Feedings", received from the Director of Nursing as current, indicated, "...Do not force the solution into the tube. Allow the solution to flow by gravity..." A, "Medication Administration			

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	per Gastric Tube Competency" form, received from the Director of Nursing on 02/16/11 at 8:15 am., indicated "...5. Inserts syringe into feeding tube and checks for aspiration of stomach content...6. If no gastric return, then verifies placement with stethoscope and air in syringe...allows medications to flow per gravity with plunger assist only as needed..." A professional resource, titled, "Geriatric Medication Handbook", dated 04/07, page 133, indicated, "...check for proper tube placement. 9. Check gastric content for residual feeding...flush tubing using gravity flow..." 3.1-44(a)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistance to prevent accidents related to an unsafe transfer due to transferring a resident without the indicated amount of assistance, which resulted in the resident being fearful of falling and causing emotional stress, for 1 of 24 residents reviewed who required assistance in transfers in a sample of 24. (Resident #22) Findings include: Resident #22's record was reviewed on 02/16/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and post right hip fracture. The resident was admitted into the facility on 01/07/11. An admission Minimum Data Set Assessment, dated 01/17/11, indicated the resident could make her self understood and could understand others, and had a	F0323	F 323 1. What is the corrective action taken for the resident found to be affected by the deficient practice?a. A complete physical and psychological assessment was completed on Resident # 22 on 1/22/11.Physical therapy re-evaluated resident to determine if change was needed in mode of transfer. Upon completion of assessment by physical therapy it was determined that residnet requires a two assist. Aide care record was reviewed and updated to include a change in mode of transfer.2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.a. All residents who are dependent on staff for transfer will be re-assessed. The aide care record and care plans will be reviewed and updated as appropriate.3. What measures will be put into place or what system changes will be made to ensure that the deficient practice	03/25/2011

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	mental status summary score of 11 (moderately impaired), and required extensive assistance of two or more staff for bed mobility and transfers The Resident Assessment Protocol report, dated 01/17/11, indicated the resident needed assistance of two staff for bed mobility and transfers. A care plan, dated 01/07/11, indicated the resident had a history of a recent fall with a right hip fracture. The approaches included to transfer the resident with two assistance. A Physical Therapy evaluation note, dated 01/08/11, indicated the resident required maximum assistance with standing. A Nurses' Note, dated 01/22/11, no time documented, indicated, "Care Concern noted...Head to toes complete s/ (without) abnormal findings...Denies any pain or discomfort..." A facility, "Incident Reporting Form", dated 01/22/11, indicated the resident made an allegation of rough handling against former CNA #7. An investigation note, dated 01/22/11, indicated an Activities Aide went to the Director of Dietary (Manager on duty) and		does not reoccura. Nursing staff will be re-serviced regarding mobility and transfers and following aide care card and care plan.4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in placea. Restorative Staff will perform weekly audits on residents who are dependent for transfer, to determine mobility status and that appropriate transfer is being followed.Audits will be done weekly for one month then bi weekly for one month and monthly for four months .Results of audits will be reviewed by Director of Nursing who will present findings to Q/A to determine if audits are to continued after six month.	

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	informed her the resident indicated she had a bad experience with one of the CNA's this morning. The note from the Director of Dietary indicated, "...The aide told her to get up for breakfast and the resident stated she needed help to do that and the aide said that she could stand by her self (sic) and didn't need any help. resident got herself to sitting position...and then held on to the aides (sic) arm which at that point the aide pushed her hand off her arm. Resident was afraid of falling..." An investigation note, dated 01/22/11 at 1:50 p.m., indicated the Nurse Manager spoke with the resident and the resident identified former CNA #7 as the CNA who took care of her that morning. The note indicated former CNA #7 was removed from the unit. The note indicated the resident had told CNA #7 she could not stand and the CNA had told her she could. The note indicated the resident said, "...when it was time to get in to the wheel chair (sic) from the bed she said ok (resident name) stand up and she placed a hand under my arm and hoisted me up to a stand. It was then that my knees gave out and I grabbed her pant leg for support. She yelled at me to let go and slapped my hand off of her. This caused me to quickly sit in the wheel chair (sic) and I was so afraid I was going to fall and			

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	brake (sic) my hip again..." An investigation note, dated 01/22/11 at 11 a.m. from former CNA #7, indicated, "...she requested to get dress (sic) and up (arrow up) in the wheelchair at 11:00 a.m...I asked her to stand up (arrow up) for me and I told her I would be right here to assist her. I was standing on her left side and placed my left arm underneath her arm and said on the count of 3 we are going to stand up (arrow up). I counted to 3 and she stood up (arrow up). As I was pulling her pants up (arrow up), she was grabbing onto my uniform, extremely tight, making it difficult for me to assist her. I told (resident name) she is going to have to let go of my uniform, I never slapped, shoved, pushed or grabbed her hand at any point..." During an interview on 02/16/11 at 11:25 a.m., the Reclaim Unit Manager indicated former CNA #7 had only worked as needed and the CNA was not familiar with the resident. During an interview on 02/16/11 at 11:35 a.m., the Reclaim Unit Manager indicated the resident did not have a Care Sheet, which explains what help the resident needed. She indicated if the resident had a Care Sheet, it would have told CNA #7 the resident required two people to assist			

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	the resident with transfers. 3.1-45(a)(2)			
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to ensure Registered Dietician's recommendations were followed up on and nutritional supplements were given as ordered for a resident with continued weight loss, for 1 of 6 resident's with weight loss in a sample of 24. (Resident #84) Findings include:	F0325	F Tag 325 1. What is the corrective action taken for the resident found to be affected by the deficient practice? a. On 3/01/11 resaident # 84 was placed on hospice. On 3/15/11 dietician re-evaluated resident and orderes received to discontinue healthshake. On 2/16/11 a clarification order was writtened to increase med pass 120 cc qd at 6:00am 2. How other residents have the	03/25/2011

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1. Resident #84's record was reviewed on 2/16/11 at 10:50 a.m. Resident #84's diagnoses included, but were not limited to, osteoarthritis, hypertension, hiatal hernia, and basal cell carcinoma.

A care plan, dated, 02/14/10, indicated the resident had significant weight losses. The approaches indicated, "1. serve diet per MD order...monitor meal intakes...med pass 180 ml's (milliliters) qid (four times a day)...1/17/10 (sic 2011) Continue med pas 180 mls qid and add med pass 120 mls qd (daily)."

The following weights were as follows, as indicated on the weight record:

11/10	154 pounds
11/17/10	149
11/24/10	143
12/1/10	139
12/8/10	135
12/15/10	133
12/22/10	136
12/29/10	141
1/5/11	136
1/12/11	132
1/19/11	130
1/26/11	127
2/6/11	126
2/9/11	125
2/17/11	123

potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. The dietician will review all residents with a significant weight loss.Dietician will document on physican order sheet recoomendations as indicated 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Dietary Director/designee will provide RCC's/Designee with a weekly dietary consultation report adressing the recommendation. b. RCC/Designee will audit medcial records weekly for residents at risk for weight loss to ensure dietary recommnedations have been followed.c. RCC/Designee will report weekly findings of audits to the Director of Nursing/Designee . Director of Nursing /Designee will review weekly audits and report findings to Q/A monthly 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. Dietary Director /designee will provide RCC with dietary consultation reports weekly . b. RCC will preform weekly medical record audits on residents with weight loss to ensure that dietary recommendation have been followed . c. RCC will report

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	2/23/11 124 A Nutritional Progress Notes, dated 1/17/11, indicated "...sig (significant) wt loss...x 6 months- 34#/20% noted...current wt is 132# showing a 4# wt loss x 1 week...meal intakes remain poor however continues to drink Med Pass 180 ml QID...will recommend increase (arrow pointing up) Med Pass to 180 ml QID (resident already on since 12/14/10) and add 120 ml daily..." A Physician's order, dated 1/17/11 at 11:30 a.m., indicated "...recommend Med Pass 180 ml QID and Med Pass 120 ml q (every) day." A Medication Record, dated 1/1/11 through 1/31/11, indicated the Med Pass 120 ml po daily was started on 1/18/11 and given as ordered. A Nutritional Progress Notes, dated 1/31/11, indicated "...Weekly wt 127# shows a 14# loss x 4 wks (9.93%)...diet changed to pureed on 1/26/11 however, po (by mouth) intake remains poor...RD informed today that SS (Social Services) is involved in case for possible Hospice eval. Further decline in nutritional status, wt loss likely to occur if condition overall does not improve. Offer food and fluid as tolerated and accepted by resident...."		findings of audits to Director of Nursing /Designee weekly .Director of Nursing/Designee will review weekly audits and report findings to Q/A monthly for six month. This will be ongoing .	

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A Resident Daily Consumption Record, dated January 2011, lacked documentation of the resident's food and fluid consumption for breakfast on 1/1, 1/3-1/15, 1/17-1/19, 1/23, 1/30 and 1/31, for lunch on 1/1, 1/3-1/5, 1/7, 1/9-1/12, 1/15, 1/16, 1/18-1/20, 1/22, 1/23, 1/30, and 1/31 and for dinner on 1/1, 1/3, 1/5-1/9, 1/11, 1/12, 1/13, 1/16, 1/18, 1/20, 1/26, 1/27, and 1/30.

During an interview with LPN #13, on 2/18/11 at 10:55 a.m., she indicated the food consumption had "a lot of holes, they should be filled in."

A Nutritional Progress Notes, dated 2/11/11, indicated "...Sig wt loss x...6 months 45#/26.32%...Remains on pureed diet /c (with) Med Pass 180 ml QID and 120 ml q (every) day. Meal intakes remain poor despite being on megace...med pass per current orders adequate to meet est (estimated) caloric and protein needs. Per nursing note dated 2/9/11, "(physician's name) and (son's name) in agreement at this time-no hospice evaluation." continue /c med pass as per orders...will have Dietary send health shakes on meal trays...."

A Request For Diet Changes form, addressed to nursing, dated 2/11/11,

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	indicated "continue Med Pass as per orders, Dietary to send health shake on meal trays." Physician's telephone orders written by the Registered Dietician, dated 2/11/11, lacked documentation to indicate the healthshake had been ordered as outlined by the Registered Dietician. A Medication Record, dated 2/11, lacked documentation of healthshakes being given. During an interview with the Dietary Manager, on 2/16/11 at 12:11 p.m., she indicated "We don't give the healthshakes without an order. The Dietician didn't write an order for the healthshakes. We will get an order right now." A Medication Record, dated 2/1/11 through 2/28/11, indicated med pass 120 ml's p.o. qd to be given at 6 a.m. It was not initialed as given on 2/11, 2/12, 2/13, 2/14, 2/15 and 2/16 due to "Duplicate order" written on the Medication Record. During an interview with LPN #9, on 2/16/11 at 2:50 p.m., she indicated "I don't know why they wrote duplicate order, she is supposed to be getting the 120 ml everyday in addition to the 180 ml four times a day."			

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	During an observation of lunch meal, on 2/16/11 at 12:20 p.m., the resident did not receive a healthshake. A facility policy titled "Nutrition and Weight Loss", dated 04/09, received as current from the Director of Nursing, indicated, "...staff will identify residents at risk for weight loss to assess and describe prevention activities to address the risk, and provide an individualized plan to intervene when significant unintended weight loss occurs..." 3.1-46(a)(1)			

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F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 of 24 residents in a sample of 24 (Residents #68 and #74) and 1 of 13 residents in a supplemental sample of 13 (Resident #65) observed receiving medications. Nine (9) errors in medication administration were observed during 41 opportunities for error in medication administration. This resulted in a medication error rate of 21.95%. Findings include: During an early morning medication pass observation on 02/15/11 at 7:10 a.m. through	F0332	F 332 1. What is the corrective action taken for the resident found to be affected by the deficient practice? a. On 2/15/11 ,RN # 4 was verbally counseled, at the time of incident, about following medication administration policy with emphasis on following physician orders related to timeliness for Resident 74. b. On 2/15/11 RN # 4 was verbally counseled at the time of incident about following medication administration policy with emphasis on following physician orders related to timeliness for Resident 68 c. On 2/15/11 RN # 4 was verbally counseled at the time of incident about following medication administration policy with emphasis on following physician orders related to timeliness for Resident 65 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All residents have the potential to be affected and all nurses will be re-educated on medication pass regulation and facility policy. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. A medication pass in-service will be presented to all licensed staff also to include	03/25/2011

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	8:05 a.m., with RN #4, the following was observed: A) At 7:10 a.m., RN #4 prepared Resident #74's medication, which consisted of Potassium liquid 20 milliequivalent (MEQ) and acidophilus extra strength (probiotic). RN #4 gave the medication at 7:20 a.m. Review of the Medication Administration Record (MAR), dated 2/11, at the time RN #4 was preparing the medications, the MAR indicated the medications were scheduled for 6 a.m. During an interview at the time of the observation, RN #4 indicated she has an hour each way to give the medication, and the medication was given late.		QMA's b. A medication pass skill competency will be completed on all licensed staff and QMA.'s 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. RCC/ Designee will complete random medication pass observations one on each shift monthly ensuring different nurses and QMA are observed. for six month. Observations findings will be reviewed by Director of Nursing monthly and findings reported to Q/A for six month. Q/A will recommend if monitoring is to continue.	

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The resident's record was reviewed on 02/15/11 at 8:05 a.m. The resident's diagnoses included, but were not limited to, dementia and gastritis.

The resident's Physician's Recapitulation Orders, dated 02/11, indicated orders for potassium chloride 20 MEQ, twice daily at 6 a.m. and 6 p.m. and acidophilus extra strength one tablet three times daily at 6 a.m., 12 p.m., and 6 p.m.

B) At 7:22 a.m., RN #4 prepared Resident #68's medications, which consisted of Synthroid (hypothyroid medication) 100 MCG (micrograms) and Novolog insulin 2 units. The resident received the medications at 7:35 a.m.

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	The resident's MAR, dated 02/11, indicated the Synthroid and Novolog insulin were scheduled to be given at 6 a.m. The resident's breakfast was served at 8 a.m. Resident #68's record was reviewed on 02/15/11 at 8:10 a.m. The resident diagnoses included, but were not limited to, diabetes mellitus and hypothyroidism. The resident's Physician's Recapitulation Orders, dated 02/11 indicated an order for Novolog to be given per sliding scale (amount of insulin given by results of blood sugar) at 6 a.m. and 4 p.m. and Synthroid 100 MCG daily at 6 a.m.			

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	C) At 7:40 a.m., RN #4 prepared Resident #65's medication, which included Artificial tears, citalopram 10 MG (milligrams) (antidepressant), metoprolol 50 MG (blood pressure), vitamin C 500 MG, Actos 30 MG (blood sugar), Lasix 20 MG (diuretic) two tablets, Klor-con 10 MEQ (potassium), aspirin 81 MG, lisinopril 20 MG (blood pressure), Tricor 145 MG (hyperlipidemia), and glipizide 5 MG two tabs (blood sugar). RN #4 removed the resident's medication cards from the cart and placed each medication, except the citalopram in the plastic medication cup, which she checked the card and placed the card of citalopram to the side. At 8:05 a.m., RN #4 indicated there were 11 pills, then put the			

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	medications in applesauce (there should have been 12 pills) and gave the resident her medication. While RN #4 was giving Resident #65 her medication, the resident indicated the medications were late. The resident's MAR, dated 02/11 indicated the artificial tears, citalopram, metoprolol, vitamin C, and glipizide were scheduled to be given at 6 a.m. During an interview, right after the resident's medications were given, RN #4 indicated she didn't realize she had not given the citalopram. Resident #65's record was reviewed on 02/15/11 at 8:15 a.m. The resident's diagnoses			

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	included, but were not limited to, diabetes mellitus and edema. The resident's Recapitulation Physician's Orders, dated 02/11, included the following orders: Artifical Tears one drop both eyes twice daily glipizide 5 MG 2 tablet at 6 a.m. and one tablet at 6 p.m. metoprolol 50 MG twice daily vitamin C 500 MG twice daily citalopram 10 MG daily A professional resource, titled, "2010 Nursing Spectrum Drug Handbook", page xv, indicated, "...incorrect timing of drug administration accounted for 43% of medication errors...usually, a dose should be given within 30 minutes before or after the time			

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	specified in the order..." 3.1-48(c)(1)			
F0368 SS=C	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on interview, the facility failed to ensure residents were offered snacks at bedtime daily for 8 of 10 residents interviewed in the group meeting. This included 1 of 1 resident interviewed about bedtime snacks in a sample of 24 (Resident #48) and 7 of 9 residents	F0368	F3681. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident # 48 b. Resident # 47 c. Resident # 33 d. Resident # 53 e. Resident #65 f. Resident # 82 g. Resident # 87 h. Resident#100 i. A snack cart will be used to deliver snacks to each room of each residents listed above. 2.	03/25/2011

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	interviewed about bedtime snacks in a supplemental sample of 13 (Residents #33, #47, #53, #65, #82, #87, and #100). This had the potential to affect 140 residents with oral diet orders, who resided in the healthcare facility. Findings include: During the Resident Group meeting with 10 residents, identified by the Activity Director as alert and oriented to person, place and time at all times, 8 of the 10 residents (Residents #33, #47, #48, #53, #65, #82, #87, and #100) indicated the staff did not offer them a bedtime snack at night. They indicated that someone used to come around with a snack cart and offer snacks at bedtime, but they had stopped doing that. The residents were identified as living on the Reclaim and the Eden units of the building. During an interview on 12/17/11 at 10 a.m., LPN #14 indicated the staff does not have a form to document the bedtime snacks were offered and accepted. 3.1-21(e)		How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All residents have the potential to be affected so they will be included and will be offered utilizing the snack cart delivery. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Dietary personnel will be in charge of delivering snacks via the snack cart at h.s. which will be documented on the hs snack form. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. Dietary manager/designee will do 10 random audits weekly by asking residents if they have been receiving snacks. Dietary manager /Designee will present findings to the Q/A committee monthly for six month. Q/A will recommend if audits need to be continued.	

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to dispose of medications in accordance with the standards of practice, related to the facility being unable to account for a discharged resident's medication for 1 of 3 discharged residents. (Resident #185) Findings include: Resident #185's record was reviewed on 02/17/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and hypertension. The resident was discharged to the hospital on 01/14/11 and was not currently in the facility.	F0425	F 4251. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident # 185 had been discharged from facility and medication had been sent back to pharmacy without drug disposition sheet attached.Pharmacy was notified and the medication had already been disposed therefore no further action could be taken. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All other resident have the potential to be affected by this deficient practice therefore licensed staff will be re-educated on the importance of completing the drug destruction disposition record at discharge.	03/25/2011

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	The resident's Physician's Recapitulation Orders, dated 01/11, indicated the resident was on the following medications at the time of discharge: multivitamin daily Prilosec (stomach medication) 20 MG (milligrams) every morning Zocor (cholesterol medication) 80 MG every bedtime Colace 100 MG (stool softener) twice daily Geodon (antipsychotic) 20 MG, two capsules daily Geodon 20 MG every evening Lopressor (blood pressure) 25 MG twice daily Namenda (Alzheimer's medication) 10 MG twice daily Norvasc (cardiac) 5 MG daily Aspirin 81 MG daily Depakote (for behaviors) 125 MG two capsules every morning and three capsules at bedtime Ferrous Sulfate (iron) 325 MG daily Lasix 20 MG daily Razadyne ER (Alzheimer's) 16 MG daily Cozaar (blood pressure) 100 MG daily Acetaminophen 650 MG every four hours as needed for fever Robitussin DM every four hours as needed for cough There was a lack of documentation to indicate the resident's medication had		3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. An in-service will be presented on drug destruction policy and procedure and proper use of forms. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. Medical records will audit discharge records to ensure that drug disposition records are present and completed for six month and report findings to Director of Nursing. The Director of Nursing will report findings to Q/A for six months .Q/A will recommend if audits are to continue.	

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	been returned to the pharmacy or had been destroyed by the facility. During an interview on 02/18/11 at 10 a.m., the Reclaim Unit Manager indicated she was not sure where the medications were. She indicated there was no medication disposition form for the resident's medication. 3.1-25(a)			
F0463 SS=D	The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure residents' call lights were in working order in 2 of 12 bathrooms observed for call lights on 3 of 3 units in the facility. This had the potential to affect 3 residents in a supplemental sample of 13, who use bathrooms of rooms #I and #129. (/Resident #14, #103 and #104) Findings include: Observations during the environmental tour on 02/17/11 at 9:05 a.m. through 11:15 a.m., with the Executive Director, the Maintenance Director, The	F0463	F 4631. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident # 14 the call light was fixed and is functioning 2/17/11 b. Resident # 103 the call light was fixed and is functioning 2/17/11 c. Resident # 104 the call light was fixed and is functioning 2/17/11 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident have the potential to be affected therefore all call lights will be checked to ensure that they are in working order. . 3. What measures will be put into	03/25/2011

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	Housekeeping Director, and Maintenance Person #16, the call light in the bathroom of Room #I on the Haven Unit, did not activate when the call light was pulled. During an interview at the time of the observation, the Maintenance Director immediately notified another maintenance staff member to come and fix the call light. The call light in the bathroom of Room #129 on the Eden unit, did not activate when the call light was pulled. The Maintenance Director immediately called another maintenance staff member to fix the bathroom call light. During the initial tour of the facility, on 02/14/11 at 11:05 a.m., LPN # 17, identified resident #14 as being continent of bowel and bladder. She indicated the resident required assistance with activities of daily living (ADLS). During the initial tour of the facility on 02/14/11 at 9:50 a.m., the Eden Unit Manager identified Resident #103 and #104 as incontinent of urine. She indicated the residents required assistance with ADLS. During an interview on 02/18/11 at 8:45 a.m., the Executive Director indicated the facility had no documentation to indicate		place or what system changes will be made to ensure that the deficient practice does not reoccur a. Maintenance will conduct 10 random call light checks weekly and correct as approriate for four weeks.b. A complete audit of call lights will be conducted monthly as part of preventative maintenance program.Findings will be documented on preventative maintenance log.c. At anytime a call light is idenified as not functioning there is a current maintenance form that is forwarded to the maintenance department.The Maintenance Director reviews all work requisitions and assigns work orders,call light being a priority. d.Until maintenance can fixed call light the nursing staff will provide a bell for resident.4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. The Maintenance staff will provided weekly call light audits to the Maintenace Director who will report findings of audits to Administrator for one month. The Call loght preventive maintain log will be reviewed monthly by the Maintenace Director and finding reproted to Q/A and thiis process will be ongoing.	

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	the call lights were being checked during the preventative maintenance rounds. He indicated the maintenance and nursing department monitors the functions of the call lights. He indicated an audit of 100% of the call lights had been completed. 3.1-19(u)(2)			
F0505 SS=E	The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to promptly notify residents' physicians of laboratory results for 5 of 24 residents reviewed for laboratory results and physician's notification in a sample of 24. (Residents #23, #55, #66, #75, and #185) Findings include: 1. Resident #23's record was reviewed on 02/15/11 at 11 a.m. The resident's diagnoses included, but were not limited to, renal insufficiency and Parkinson's	F0505	F 5051. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident #23: renal function study for 2/10/11 is now present in chart. b. Resident #55: BMP is in chart and physician has been notified. c. Resident #66: Keppa report is in chart and physician has been notified d. Resident #75: CBC and Chem. 7 is now in chart and physician has been notified e. Resident #185: This was a discharged record prior to survey 1/21/11 so we are unable to correct. 2. How other residents have the potential to be affected by the same deficient practice will	03/25/2011

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	Disease. A physician's order, dated 01/28/11, indicated an order for renal function studies every three days. The resident's record, indicated the last renal function studies had been completed on 02/07/11. There was no result for the 02/10/11 renal function studies in the resident's record. During an interview on 02/15/11 at 1:15 p.m., LPN #2 indicated she notified the lab and they were going to fax the renal function studies over. She indicated she would notify the resident's physician of the results. 2. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/19/11, indicated an order for a CBC (complete blood count), BMP (basic metabolic profile) (electrolytes), and Digoxin level with the next lab draw and weekly. The resident's record indicated the CBC and Digoxin level had been completed on 01/21/11 (next lab day). There was a lack of documentation to indicate the BMP had		be identified and what corrective action will be taken. a. All resident charts will be reviewed to ensure that lab orders have completed as ordered, report is available in chart and physician has been notified 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Re-in-service licensed staff on lab policies and procedures b. Re-in-service physician notification policy and procedures 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. RCC /Designee will review lab orders, lab book and medical record daily to ensure that labs were drawn as ordered, results are in chart and physician has been notified for six months .Results of audits will be reported to Director of Nursing weekly and findings will be reported to Q/A monthly for six month. Q/A will determine if daily audits are to continue.	

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	been completed with the other labs. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the BMP had been ordered and completed, but the facility did not have the results. She indicated she could pull it up on her computer. She indicated if the results were not in the charts, then the physician was unaware of the results. 3. Resident #185's record was reviewed on 02/17/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and pulmonary vascular disease. A physician's order, dated 01/11/11, indicated an order for a CBC to be completed in the morning. The resident's Nurses' Notes, dated 01/12/11 through 01/14/11, lacked documentation the CBC had been completed and the physician had been notified of the results. The resident's record lacked documentation of the results of the CBC ordered on 01/11/11. During an interview on 02/18/11 at 10 a.m., the Reclaim Unit Manager indicated the CBC had been completed, but the			

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	results had not been sent to the facility and the physician had not been notified of the results. 4. Resident #66's record was reviewed on 02/18/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, seizure disorder and dementia. A physician's order, dated 12/08/10, indicated for Kepra levels (seizure medication) to be completed weekly. The Kepra level lab results, dated 01/19/11, 01/26/11, and 02/16/11, indicated, the Kepra levels had been drawn by lab and the results were "in-lab." There was a lack of documentation in the resident's record to indicate what the Kepra results were. During an interview on 02/18/11 at 10:05 a.m., LPN #13 indicated the nurses' should have followed up on the lab results. During an interview on 02/18/11 at 10:15 a.m., LPN #13 indicated she would call the lab and get the results. She indicated the physician had not been notified of the results because the labs only come to the facility. 5. Resident #75's record was reviewed on			

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	02/17/11 at 11:27 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension. The Physician's Recapitulation orders, dated 01/11 indicated an order for a CBC and Chem 7 (electrolytes) to be completed monthly. The last CBC and Chem 7 in the resident's record was dated 12/24/10. During an interview on 02/17/11 at 2:37 p.m., LPN #15 indicated she would notify the lab to check on the results of the January CBC and Chem 7. During an interview on 02/17/11 at 2:55 p.m., LPN #15 indicated the CBC and Chem 7 had been completed. She indicated the lab results were not in the chart . She indicated the physician had not been notified of the lab result. The CBC and Chem 7 was received at the facility per fax on 02/17/11 at 2:44 p.m. The CBC and Chem 7 had been completed on 01/28/11. 3.1-49 (f)(2)			

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F0507 SS=E	The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Based on record review and interview, the facility failed to ensure residents' laboratory reports were in the residents' records for 5 of 24 residents reviewed for labs in a sample of 24. (Residents #23, #55, #66, #75, and #185) Findings include: 1. Resident #23's record was reviewed on 02/15/11 at 11 a.m. The resident's diagnoses included, but were not limited to, renal insufficiency and Parkinson's Disease. A physician's order, dated 01/28/11, indicated an order for renal function studies every three days. The resident's record, indicated the last renal function studies had been completed	F0507	F 5071. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident #23: renal function study for 2/10/11 is now present in chart. b. Resident #55: BMP is in chart and physician has been notified. c. Resident #66: Keppa report is in chart and physician has been notified d. Resident #75: CBC and Chem. 7 is now in chart and physician has been notified e. Resident #185: This was a discharged record prior to survey 1/21/11 so we are unable to correct. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident charts will be reviewed to ensure that lab orders have completed as ordered, report is available in chart and physician	03/25/2011

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	on 02/07/11. There was no result for the 02/10/11 renal function studies in the resident's record. During an interview on 02/15/11 at 1:15 p.m., LPN #2 indicated she notified the lab and they were going to fax the renal function studies over. 2. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/19/11, indicated an order for a CBC (complete blood count), BMP (basic metabolic profile) (electrolytes), and Digoxin level with the next lab draw and weekly. The resident's record indicated the CBC and Digoxin level had been completed on 01/21/11 (next lab day). There was a lack of documentation to indicate the BMP had been completed with the other labs. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the BMP had been ordered and completed, but the facility did not have the results. She indicated she could pull it up on her computer. She indicated if the results were not in the charts.		has been notified 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Re-in-service licensed staff on lab policies and procedures b. Re-in-service physician notification policy and procedures 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. RCC /Designee will review lab orders, lab book and medical record daily to ensure that labs were drawn as ordered, results are in chart and physician has been notified for six months .Results of audits will be reported to Director of Nursing weekly and findings will be reported to Q/A monthly for six month. Q/A will determine if daily audits are to continue.	

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	3. Resident #185's record was reviewed on 02/17/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and pulmonary vascular disease. A physician's order, dated 01/11/11, indicated an order for a CBC to be completed in the morning. The resident's Nurses' Notes, dated 01/12/11 through 01/14/11, lacked documentation the CBC had been completed and the physician had been notified of the results. The resident's record lacked documentation of the results of the CBC ordered on 01/11/11. During an interview on 02/18/11 at 10 a.m., the Reclaim Unit Manager indicated the CBC had been completed, but the results had not been sent to the facility. 4. Resident #66's record was reviewed on 02/18/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, seizure disorder and dementia. A physician's order, dated 12/08/10, indicated for Kepra levels (seizure medication) to be completed weekly.			

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	The Kepra level lab results, dated 01/19/11, 01/26/11, and 02/16/11, indicated, the Kepra levels had been drawn by lab and the results were, "in-lab". There was a lack of documentation in the resident's record to indicate what the Kepra results were. During an interview on 02/18/11 at 10:05 a.m., LPN #13 indicated the nurses' should have followed up on the lab results. During an interview on 02/18/11 at 10:15 a.m., LPN #13 indicated she would call the lab and get the results. 5. Resident #75's record was reviewed on 02/17/11 at 11:27 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension. The Physician's Recapitulation orders, dated 01/11 indicated an order for a CBC and Chem 7 (electrolytes) to be completed monthly. The last CBC and Chem 7 in the resident's record was dated 12/24/10. During an interview on 02/17/11 at 2:37 p.m., LPN #15 indicated she would notify the lab to check on the results of the January CBC and Chem 7.			

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	During an interview on 02/17/11 at 2:55 p.m., LPN #15 indicated the CBC and Chem 7 had been completed. She indicated the lab results were not in the chart . The CBC and Chem 7 was received at the facility per fax on 02/17/11 at 2:44 p.m. The CBC and Chem 7 had been completed on 01/28/11. 3.1-49(f)(4)			
F0513 SS=D	The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. Based on record review and interview, the facility failed to ensure residents' x-rays were in the residents' clinical records for 2 of 24 residents reviewed for x-ray results in a sample of 24. (Residents #55 and	F0513	F 5131. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident #55: documentation is in chart and x-ray report is present b.	03/25/2011

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	#185) Findings include: 1. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/25/11 at 12 p.m., indicated an order for an x-ray of the pelvis and the left hip. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the resident had the x-rays completed as ordered. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's record. She indicated there was no documentation in the resident's record the resident had went for the x-ray. She indicated she would notify the facility's bus driver to see if she had taken the resident for the x-ray.		Resident #185: this is a closed record and report was placed in closed record.2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident charts will be reviewed to ensure that x-ray have completed as ordered ,report is available in chart and physician has been notified 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Re-in-service licensed staff on follow-up of x-ray orders to ensure reports are on chart. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. RCC /Designee will review x-ray orders to ensure that results are in chart and physician has been notified, Charts will be audited weekly to ensure x-ray report is on chart for one month, then bi weekly for one month and then monthly for 4 months .Results of audits will be reported to Director of Nursing monthly and findings will be reported to Q/A monthly for six month. Q/A will determine if daily audits are to continue.	

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	During an interview on 02/16/11 at 12:25 p.m., Bus Driver #1 indicated she had taken the resident for the x-ray, before the resident's physician's appointment. She indicated the x-ray was done and the physician had the results. The Reclaim Unit Manager indicated during the interview, the result was sent to the physician's office and the facility did not have a copy of the result. 2. Resident #185's record was reviewed on 02/17/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and pulmonary vascular disease. A physician's order, dated 01/11/11 indicated an order for a chest x-ray. The Nurses' Notes, dated 01/12/11 at 2 p.m., indicated the physician had been notified of the chest x-ray results. The resident's record lacked documentation of the chest x-ray report from 01/12/11. During an interview on 02/17/11 at 2:15 p.m., the Reclaim Unit Manager indicated the chest x-ray report was not in the resident's record. 3.1-49(j)(4)			

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F0514 SS=E	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure medical records were complete and accurate related to, physicians orders recapitulations, intake and output records, nurses' notes, and food consumption record for 5 of 24 residents reviewed for complete and accurate medical records. (Residents #55, #84, #98, #119, and #187) Findings include: 1. Resident #98's record was reviewed on 2/15/11 at 9:13 a.m. Resident #98's diagnoses included, but were not limited	F0514	F 5141. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Resident# 98 who is on fluid restriction I&O was not filled out completely staff was re-in-serviced on I&O policy and procedure b. Resident # 187 who is on fluid restriction I&O was not completed since it is a closed record and we unable to make corrections c. Resident # 119 physician order was clarified and albuterol is being given as ordered. d. Resident # 84 Food consumption was not completed in January and we are unable to complete at this time. This resident is now on hospice and	03/25/2011

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	155637	A. BUILDING 00 B. WING	02/23/2011

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	to, legally blind, end stage renal, anemia, and diabetes. A Physicians Orders Recapitulation, dated February 2011, indicated the resident was on a 1200 ml (millimeters) fluid restriction. The resident's intake and output record for February 2011, lacked documentation of the resident's intake on the following dates: 7-3 shift on 2/6/11, 2/7/11, and 2/14/11. During an interview on 2/15/11 at 10:23 a.m., LPN #11 indicated the intake and output record "should be filled out." 2. Resident #187's closed record was reviewed on 2/17/11 at 1:55 p.m. Resident #187's diagnoses included but were not limited to, knee joint replacement, hypertension, and difficulty in walking. A physician's order, dated 1/2/11, indicated the resident was on a 1200 ml fluid restriction. The resident's intake and output record for January 2011, lacked documentation of the resident's intake on the following dates: 7-3 shift on 1/3/11, 1/9/11, and 1/10/11.		refuses to eat but takes med pass 5 times a day which documented on MAR. e. Resident # 55 Santyl order was clarified and discontinued and new order was written for waffle boots and orthics have been discontinued. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident who are on Intake and Output charts will be reviewed to ensure documentation to complete. b. All resident's food consumptions sheets will be reviewed to ensure that documentation is complete. c. All physician orders sheets will be reviewed for accuracy. And correction made as needed. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. Licensed professional will be re-In-serviced on physician order policy and procedures b. Nursing staff will be re-in-service on I&O policy and procedure as well as food consumption policy and procedure and importance of documentation 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. The RCC/designee will audit the Physician Orders, Intake/output	

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	3. Resident #119's record was reviewed on 2/17/11 at 11:25 a.m. Resident #119's diagnoses included, but were not limited to, failure to thrive, congestive heart failure, and cerebral vascular accident (stroke). A Physician's Orders Recapitulation, dated February 2011, indicated the following physician's orders: 1/21/11 "albuterol/Ipratropium 1 vial per neb tx (breathing treatment) 3 times daily." 1/21/11 "albuterol 0.083% neb 1 vial per neb tx every 4 hours prn (as necessary) shortness of breath." This physician's order was marked out with the word duplicate. During an interview on 2/17/11 at 1:30 p.m., the Restorative Nurse indicated the physician's orders were not the same. The Restorative Nurse indicated the two orders were not duplicates. The Restorative Nurse indicated she did not know why the nurse marked duplicate. 4. Resident #84's record was reviewed on 2/16/11 at 10:50 a.m. Resident #84's diagnoses included, but were not limited to, osteoarthritis, hypertension, hiatal hernia, and basal cell carcinoma.		and Food consumption weekly x1 month, biweekly x 2 months and monthly x 3 months. Director of Nursing /designee will review findings monthly and report to the QA committee monthly for 6 months. The QA committee will recommend any further action.	

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	A Resident Daily Consumption Record, dated January 2011, lacked documentation of the resident's food and fluid consumption for breakfast on 1/1, 1/3-1/15, 1/17-1/19, 1/23, 1/30 and 1/31, for lunch on 1/1, 1/3-1/5, 1/7, 1/9-1/12, 1/15, 1/16, 1/18-1/20, 1/22, 1/23, 1/30, and 1/31 and for dinner on 1/1, 1/3, 1/5-1/9, 1/11, 1/12, 1/13, 1/16, 1/18, 1/20, 1/26, 1/27, and 1/30. During an interview with LPN #13, on 2/18/11 at 10:55 a.m., she indicated the food consumption had "a lot of holes, they should be filled in." 5. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. The resident's admission orders, dated 01/17/11, indicated an order for Waffle Boots at bedtime and Orthotic shoes during the day. A physician's order, dated 01/25/11, indicated an order to discontinue Santyl (debridement ointment) to the sacral ulcer. The resident's Recapitulation Physician's Orders, dated 02/11, and signed by the nurse as reviewed on 01/31/11, lacked documentation of the physician's order for			

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	the Waffle Boots, Orthotic shoes and the discontinuation of the Santyl ointment. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the orders should have been carried over to the Recapitulation Orders, dated 02/11. 3.1-50(a)(1) 3.1-50(a)(2)			
R0000	The following State Residential findings are in accordance with 410 IAC 16.2-5.	R0000	N/A	

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R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify a resident's physician related to a weight loss for 1 of 7 residents reviewed for weight loss in a sample of 7. (Resident #165) Findings include: Resident #165's record was reviewed on 02/18/11 at 9:45 a.m. The resident's diagnosis included, but was not limited to, hypertension. The resident's weight record, dated 04/10, indicated the resident's weight was 137 pounds. The weight record indicated the resident's weight on 01/04/11 was 123 pounds. This was a 10.2% weight loss in nine months. During an interview on 02/21/11 at 9:40 a.m., the Wellness Care Coordinator indicated when the weight loss had been brought to her attention on 02/18/11, she notified the resident's physician.	R0036	R00361. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Physician was notified on 2/19/11 of the weight loss and the physician ordered weekly weights, ensure twice a day, lab work CBC, BMP, T3,T4,TSH ,Total Protein, Albumin and Pre Albumin for resident #165. The Resident is alert and oriented and responsible for self. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All assisted living residents will be reweighed to determine a significant weight change. Significant weight changes will be reported to physician and responsible party as needed. When a significant weight change has occurred an assessment will be completed a new service plan initiated if appropriate.3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. The Wellness Care Coordinator will	03/25/2011

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	A Physician's Concern Report, dated 02/19/11, indicated the following new orders, "1. weekly weights 2. CBC (complete blood count) with differential, Basic Metabolic Panel (electrolytes), T3, T4, TSH (thyroid tests), total protein, albumin, pre albumin. 3. Ensure (dietary supplement) bid (twice a day)."		meet with medical director monthly to review weight changes. The Wellness coordinator will document meeting outcome on comment section of service plan. . When a significant weight change has occurred an assessment will be completed a new service plan initiated if appropriate.4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place Service plans will audited by nurse monthly. Audits will be reviewed by Director of Nursing monthly times 3 months and then quarterly for 6 months. Findings will be reported to Q/A quarterly for six month	

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure services offered to the resident were documented on the resident's service plan related to medication management and mobility for 2 of 7 residents reviewed for service plans in a sample of 7. (Residents #158 and #178)	R0217	R 2171. What is the corrective action taken for the resident found to be affected by the deficient practice? a. The service plan for resident # 159 was reviewed and updated on 2/21/11 to reflect self medication administration, and mobility. b. The service plan for Resident 178 reviewed and updated 2/21/11 to reflect self medication administration. 2. How other	03/25/2011

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	Findings include: 1. Resident #159's record was reviewed on 02/21/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, muscle weakness and osteoarthritis. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week. The Self-Administration of Medications Assessment, dated 11/12/10, indicated the resident could safely self administer her medications. The resident's,Service Plan Assessment, dated 11/12/10, indicated the resident required maximum supervision for medication management administration. The form indicated, "maximum supervision-Assistance Management for compliance, irregular regimen, facility intervention, oversight or direct management or medication distribution...Needs order of supplies, coordination of securing medication and routine instruction of usage." The area on the comments section, which the Wellness Care Coordinator indicated was the resident's service plan, was left blank.		residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. The assisted living residents will be reassessed and service plan updated to reflect current status of medication administration and mobility. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. The licensed staff will be re-in-service on the plan policy and procedure b. The licensed staff will be re-in-serviced on the self medication administration policy. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. Charts/Service plans will be audited monthly by the licensed nurse. Monthly audits will be reviewed by the Director of Nursing.Findings will be reported to Q/A monthly for three months and the quarterly for one year.	

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	The, Service Plan Assessment, dated 11/12/10, indicated the resident required assistance for ambulation, mobility and transfers. The area on the comments section was left blank. During an interview on 02/21/11 at 8:40 a.m., the Wellness Care Coordinator indicated there were no comments written on the service plan. 2. Resident #178's record was reviewed on 02/21/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to, hypothyroidism and legally blind. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week. The Self-Administration of Medications Assessment, dated 09/23/10, indicated the resident could safely self administer her medications. The resident's MAR dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up.			

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	The resident's Service Plan Assessment, dated 09/26/10, indicated the resident required assistance with ambulation, mobility and transfers. The comments section indicated, "Uses a walker. Has had recent fall. Unable to locate 3rd floor per self if an emergency. The comments lacked documentation to indicate what service would be provided by the facility and who would provide the service. The, 09/26/10 Service Plan Assessment indicated the resident required assistance with medication management and administration. The comments section indicated, "Meds given per staff. Uses (pharmacy name). Meds need to be called in. The comments section lacked documentation the resident was self administering medication. During an interview on 02/21/11 at 8:55 a.m., the Wellness Care Coordinator indicated there was no service plan for medication management.			
R0244	(4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation, record review, and	R0244	F 2441. What is the corrective	03/25/2011

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	interview, the facility failed to ensure not more than 1 scheduled medication administration was prepared related to the facility setting up medications for a week for 3 of 4 residents who self administer medications in a sample of 7. (Residents #159 #178, and #184) Findings include: During an observation on 02/18/11 at 9:05 a.m., Resident #178 was in her apartment sitting in her recliner. The resident indicated, during the observation, she self administers her own medications after the staff set up her medications for the week. During an observation on 02/18/11 at 9:20 a.m., resident #184 was sitting in her room. There was a plastic medication container marked with the days of the week on the resident's counter in her kitchen with loose medication stored in the plastic container. During an observation on 02/18/11 at 9:25 a.m., resident #159 was sitting in her wheelchair in her room. The resident indicated, during the observation, that she takes her own medications after the facility sets up her medications for the week. 1. Resident #184's record was reviewed		action taken for the resident found to be affected by the deficient practice? a. On 2/18/11 Resident 159 was reassessed and it was determined that facility would administer medication for this resident. Physician orders were received to discontinue self administration of medication. b. On 2/18/11 Resident 178 was reassessed and it was determined that facility would administer medication for this resident. Physician orders were received to discontinued self administration of medication c. On 2/18/11 Resident 184 (hospice) was reassessed for self administration and the family agreed to set up resident medication for self administration. The resident on 2/19/11 was transferred to hospital and expired on 2/21/11. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. The assisted living residents will be reassessed to determine their ability to administer medication. b.It was determined from the reassessment completed on 2/18/11 that the 5 residents who previously had medications set up by licsened nursing staff for self administrations will now be given medicaitons by the nursing staff .3. What measures will be put into place or what system changes will be made to ensure	

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	on 02/21/11 at 8:10 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and pulmonary hypertension. The resident's Physician's Recapitulation Orders, dated 02/11, indicated the resident could self-administer her own medications. The Self-Administration of Medications Assessment, dated 09/22/10, indicated there were no concerns with the resident doing the self administration of the medication. The resident's Medication Administration Record (MAR) dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up. 2. Resident #178's record was reviewed on 02/21/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to, hypothyroidism and legally blind. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week.		that the deficient practice does not reoccur a. Assisted Living policy and procedure were reviewed and updated to ensure compliance with Indiana State regulations. b. Staff were re-in-serviced on assisted living policy and procedure on medication administration and Indiana state regulations c. A facility letter will be issued to residents/family regarding medication policies and procedure related to Assisted Living. 4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. Medication Administration policy and procedure which are in compliance with Indiana state regulations will be reviewed by Q/A committee and signed for approval. RRC/Designee will perform random weekly medication pass audits for one month , bi weekly for one month, and monthly for four months and will present audits to Director of Nursing who will report findings to Q/A for six months.	

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	The Self-Administration of Medications Assessment, dated 09/23/10, indicated the resident could safely self administer her medications. The resident's MAR, dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up. 3. Resident #159's record was reviewed on 02/21/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, muscle weakness and osteoarthritis. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week. The Self-Administration of Medications Assessment, dated 11/12/10, indicated the resident could safely self administer her medications. The resident's MAR, dated 02/11, indicated the staff at the facility were setting up the resident's medication for a week at a time and the resident was self administering the medication after they were set up.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGOLAND CHRISTIAN VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307

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	During an interview on 02/18/11 at 9:35 a.m., the Wellness Care Coordinator indicated a nurse from the facility sets up medication for six residents. She indicated they had been doing this since September.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R0356	(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure an emergency information file was immediately accessible for 1 of 5 residents reviewed for emergency files in a sample of 7. (Resident #183) Findings include: Resident #183's record was reviewed on 02/21/11 at 9 a.m. The resident's diagnoses included, but not limited to, hypertension and lumbar pain. The resident had been admitted into the facility on 01/15/11. There was a lack of documentation to	R0356	R 356 1. What is the corrective action taken for the resident found to be affected by the deficient practice?a. On 2/18/11 Resident #183 Emergency file was completed including resident's photo and Independent Admission Record.2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.a. Emergency file was reviewed on all assisted living residents and was found to be in compliance.3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccura. A new admission check list will be	03/25/2011

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	155637	A. BUILDING 00 B. WING	02/23/2011

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	indicate the resident had an emergency file available. During an interview on 02/18/11, the Wellness Care Coordinator indicated the resident did not have an emergency file.		developed to include emergency file (which includes resident Independent Admission Record and photo of resident).4. How the corrective actions will be monitored to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in placea. Emergency file will be reviewed semi-annually to determine if updates are needed.b. Resident Care Coordinator will audit emergency file semi-annually and report findings to Director of Nursing. Director of Nursing will present report findings to Q/A semi-annually for 1 year.	